Confirm Medicaid Eligibility for Eligible Hospitals

Acute Care and Critical Access Hospitals (CAH) must have:

- Medicaid discharges of at least 10% for the Medicaid patient volume,
- An average Length of Stay (LOS) of 25 days or less,
- A CCN that ends in 0001 – 0879 or 1300 – 1399 to be eligible to receive an incentive payment
- Children's Hospitals with a CCN that ends in 3300 – 3399 are automatically eligible

The hospital Medicaid patient volume is established by selecting a representative 90 day period or greater from the previous federal fiscal year. For purposes of calculating eligible hospital patient volume, a Medicaid encounter is defined as services rendered to an individual (1) per inpatient discharge, or (2) on any one day in the emergency room * where TXIX Medicaid or another State's Medicaid program paid for:

1. Part or all of the service;
2. Part or all of their premiums, co-payments, and/or cost-sharing;

*In order for emergency room encounters to count towards the patient volume the emergency department must be part of the hospital.

Note that you will be requested to enter a variety of data from your cost reports into the State Level Registry.

Representative Period	You must select a representative 90 day period or greater. This field is where you will enter the start date of the period that you have chosen to determine your Medicaid patient volume.
Total Discharges for the Representative Period	These are your total discharges for all payers, including Medicaid, for the representative period that you have chosen to determine eligibility.
Medicaid Discharges for the Representative Period	These are your total Medicaid "encounters" for the representative period that you have chosen to determine eligibility.
Location On Cost Report - *CMS 2552-96 cost report data fields*	**When totals are requested for inpatient bed days and discharges, theses totals must NOT include nursery or swing bed counts.**
Average Length of Stay	Your Average Length of Stay can be calculated using data reported in your most recently filed cost report. The most recently filed costs report is defined as the hospital cost report ending prior to the start of the current federal fiscal year *Total Inpatient Bed Days (*S-3, Part I, Column 6 listed as "Total All Patients", line 12-sum of acute care inpatient) <hr>*Total Discharges* (S-3, Part I, Column 15 listed as "Total All Patients", line 12-sum of acute care inpatient)

Prior Year Discharges Data	Discharge data from 4 prior years is used to calculate the growth rate for your hospital. Alaska has designated your most recently filed cost report for the period ending prior to the start of the current federal fiscal year plus the filed cost reports for the three years preceding it. A number is required in all fields. You may not enter a zero. (S-3, Part I, Column 15 listed as "Total All Patients", line 12-sum of acute care inpatient)	
	As listed in the SLR, if the date of your most recently filed Cost Report is 2010: *Year 4* is 2007 *Year 3* is 2008 *Year 2* is 2009 *Year 1* is 2010	
	Location On Cost Report - *CMS 2552-96 cost report data fields*	**Location on SLR's *Confirm Alaska Medicaid Eligibility* Page**
Discharges	S-3, Part I, Column 15 listed as "Total All Patients", line 12-sum of acute care inpatient	Lines 1 and 2 Total Discharges
Medicaid Inpatient Bed Days	S-3, Part I, Column 5 listed as "Total Title XIX", line 12-sum of acute care inpatient	Line 3 Total Medicaid Inpatient Bed Days
Total Medicaid Managed Care Inpatient Bed Days	Alaska does not have Medicaid Managed Care Inpatient Bed Days; it is included in the hospital calculation sheet only because it is a data field in the SLR. Hospitals may enter a "0" in this field in the SLR.	Line 4 Total Medicaid Managed Care Inpatient Bed days
Total Inpatient Bed Days	S-3, Part I, Column 6 listed as "Total All Patients", line 12-sum of acute care inpatient	Line 5 Total Inpatient Bed Days
Total Hospital Charges	Worksheet C, Part I, Column 8 listed as "Total charges", line 101	Line 6 Total Hospital Charges
Total Charity Care *(as defined for Medicare cost reporting purposes)*	S-10, Line 30, if your cost report does not contain this information determine if the hospital accounting records or hospital financial statements supports the input of charity care charges as defined for Medicare cost reporting purposes, hospitals will be required to provide this financial documentation to the Medicaid EHR Program Office.	Line 7 Hospital Charity Care Charges

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